

**TENNESSEE BOARD OF PHARMACY
NOVEMBER 18, 2003
ROOM 160 – DAVY CROCKETT TOWER
NASHVILLE, TN**

BOARD MEMBERS PRESENT:

Forrest Parmley, President
Robert Shutt, Vice President
Barbara McAndrew, Public Member
Reggie Dilliard, Member
Julie Frazier, Member
Sheila Mitchell, Member
James R. Mitchell, Member

STAFF PRESENT:

Kendall Lynch, Director
Alison Zane, Legal Counsel
Martha Agee, Board Administrator
Terrence Cannada, Pharmacist Investigator
Harry Fuqua, Pharmacist Investigator
Richard Hadden, Pharmacist Investigator
Ralph Staton, Pharmacist Investigator

The Tennessee Board of Pharmacy convened on Tuesday, November 18, 2003, in Room 160 of the Davy Crockett Tower, 500 James Robertson Parkway, Nashville, Tennessee. A quorum of the members being present, the meeting was called to order at 9:00 a.m. CST by Dr. Forrest Parmley, President. President Forrest Parmley noted Dr. Reggie Dilliard would be late attending the meeting. Dr. Parmley introduced and welcomed the new board member, Dr. Robert Mitchell. Director Kendall welcomed Dr. Mitchell on behalf of the staff. Dr. Lynch introduced two (2) students who are attending the University of Tennessee College of Pharmacy, Ms. Kara Keasler and Ms. Rhiannon Fitzsimmons.

APPROVAL OF THE MINUTES

The **minutes of the September 23 – 24, 2003**, board meeting were presented and reviewed by the Board. Dr. Robert Shutt motioned to **approve the minutes**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

ELECTION OF OFFICERS

Dr. Forrest Parmley asked for nominations for the position of President. Dr. Julie Frazier nominated **Dr. Robert Shutt for President** for the term beginning January 1, 2004 to December 31, 2004. Dr. Sheila Mitchell confirmed the nomination, seconded by Dr. Julie Frazier. All were in favor and the motion carried. Dr. Forrest Parmley asked for nominations for the position of Vice President. Mrs. Barbara McAndrew nominated **Dr.**

Tennessee Board of Pharmacy

November 18, 2003

Reggie Dilliard for Vice President for the term beginning January 1, 2004 to December 31, 2004. Dr. Julie

Frazier confirmed the nomination, seconded by Dr. Robert Shutt. All were in favor and the motion carried.

CONSENT ORDERS

ARTHUR DELASHMET, DPH

178 Old Highway 15

Ecru, MS 38841

Ms. Alison Zane, legal counsel, presented a Consent Order for Reinstatement of license for Dr. Arthur Delashmet with a probationary period of ten (10) years from September 23, 2003 to September 23, 2013. Dr. Julie Frazier motioned to **accept** the Consent Order for Reinstatement; seconded by Dr. Reggie Dilliard. All were in favor and the motion carried.

GARY LUSTER, DPH

7786 Buck Ridge Cove

Cordova, TN 38016

Legal counsel, Ms. Alison Zane, presented a Consent Order for Reinstatement of license for Dr. Gary Luster with an extension of his probationary period for a term of ten (10) years from September 23, 2002 to September 23, 2012. Dr. Luster will be required to submit to twelve (12) urine screens and six (6) breathalyzers. Dr. Reggie Dilliard motioned to **accept** the consent Order for Reinstatement; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

RAYMOND MCDUFFIE, DPH

Rt. 1, Box 280M

Pikeville, TN 37367

Ms. Alison Zane, legal counsel, presented an Agreed Order whereas Dr. Raymond McDuffie agreed to surrender his license to engage in the practice of pharmacy in the State of Tennessee. Dr. McDuffie was scheduled for a formal hearing for the forging of fifty-two (52) prescriptions filled at the pharmacy where Dr. McDuffie was the pharmacist in charge. There were no prescriptions on file. Dr. Robert Shutt motioned to **accept** the Agreed Order; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

Tennessee Board of Pharmacy
November 18, 2003
PETER PHILLIPS, DPH, PIC
SUMNER HOMECARE PHARMACY
300 Steam Plant Road #140
Gallatin, TN 37066

Legal counsel, Ms. Alison Zane, presented a Consent Order whereas Dr. Peter Phillips was in violation of Rules 1140-1-.12 (3) (g) (1) and (2) and 1140-1-.12 (7). An inspector observed a technician who was alone in the pharmacy approximately thirty (30) minutes before a pharmacist arrived. A civil penalty of \$500 was assessed. Dr. Julie Frazier motioned to **approve** the Consent Order; seconded by Dr. Sheila Mitchell. All were in favor and the motion carried.

JIM STEDMAN, DPH
P. O. Box 430
Burns, TN 37029

Ms. Alison Zane, counsel, presented a Consent Order for Reinstatement of license for Dr. Jim Stedman with a probationary term of five (5) years from September 23, 2003 through September 23, 2008. Dr. Julie Frazier motioned to **accept** the Consent Order; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

AMY R. VOORHEES, DPH
4005 Hallborough Way
Hermitage, TN 37076

Legal counsel, Ms. Alison Zane, presented a Consent Order for surrender of license for Dr. Amy Voorhees due to chemical dependency. Dr. Julie Frazier motioned to **accept** the Consent Order; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

LEGAL REPORT/COMPLAINTS

1. Case No.: L03-PHR-RBS-200315714

The complaint alleges that the Respondent, who is a wholesaler, has been involved with the distribution of counterfeit Epogen.

Recommendation: Investigation (Authorize Formal Hearing)

November 18, 2003

Dr. Sheila Mitchell motioned to **authorize a formal hearing**; seconded by Dr. Robert Mitchell. All were in favor and the motion carried.

2. Case No.: L02-PHR-RBS-200210092

The Respondent was arrested on six (6) counts of Possession of Controlled Substances with the Intent to Manufacture, Sell or Deliver and twenty-four (24) counts of Possession of Legend Drugs without a Prescription. Based on the information of the arrest, a recommendation was made for a Consent Order suspending the Respondent's license pending the outcome of a drug evaluation and the Board voted to accept that recommendation, which was rejected by the Respondent. Subsequent to that offer, we found out that the Respondent was given a Judicial Diversion because the Respondent did not appear to have an addiction problem. The circumstances surrounding this case were that the pharmacist would take her boyfriend to sit with her at the pharmacy while she worked the midnight shift. The boyfriend was taking all of the drugs. The pharmacist knew that the boyfriend was taking the drugs, but the boyfriend threatened to get her fired if she told anyone. The pharmacist is currently practicing pharmacy out of state. Based on that information, the Board voted to send the Respondent a letter requesting that the Respondent place her license in inactive status and notifying the Respondent that if intends to work in Tennessee, she must personally appear before the Board. The Respondent rejected the offer.

Recommendation: Formal Hearing

Dr. Reggie Dilliard motioned to **accept counsel's recommendation**; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

3. Case No.: L03-PHR-RBS-200316098

The Complainant alleges that she received the incorrect labels on two prescriptions, Zanaflex (1 tablet tid) and Prednisone 10 mg (5,5,5, 4,4,4, 3,3,3, 2,2,2, 1,1,1). As a result, the Complainant injected five (5) Zanaflex tablets and became incoherent, dizzy, lightheaded and extremely drowsy. The Complainant further alleges that she did not receive any patient counseling. The DPh entered the prescriptions into the computer and counseled the patient; the DPh added that although she is not personally familiar with the Complainant, it is their "standard practice to thoroughly counsel the patient on the Prednisone taper instructions". The DPh also states that a family member called about the Prednisone dose and the directions were again explained to that person over the phone. The PIC states that he does recall checking these prescriptions, but does not recall looking in the bottles, even though it is his standard practice to do so. The PIC was present the day the prescriptions were returned to the pharmacy and confirmed that the medications were in the incorrect bottles.

Previous Complaints: PIC: None

DPh: None

Pharmacy: None

Recommendation: Letter of Warning to D.Ph.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Mitchell. All were in favor and the motion carried.

November 18, 2003

4. Case No.: L03-PHR-RBS-200316029

The Complainant alleges that he was denied a refill of his prescriptions which caused him to be without his diabetes and bladder controlled medication. The pharmacist responded that due to an altercation that the Complainant had with another patient at the drive-thru window, the pharmacist informed the Complainant that he would no longer accept his business and that he would move his prescriptions to another pharmacy of his choice. The pharmacist did in fact, transfer the Complainant's prescriptions; however, over one (1) year later, the Complainant returned to the Respondent-pharmacy and requested that his prescriptions be moved back there. At that time, the pharmacist told the Complainant that they would not accept his business and referred him to another pharmacy in the area.

Previous Complaints: Pharmacy: None

DPh: None

Recommendation: Dismissal

Dr. Robert Shutt motioned to **accept counsel's recommendation**; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

5. Case No.: L03-PHR-RBS-200316317

The Complainant alleges that the incorrect prescriber's name was placed on the dispensing label of the prescription and that another prescription (Neurontin) was misfilled by shorting him eight (8) tablets. The pharmacist (AL) who filled the prescription with the incorrect name states that the physician's signature was not clear and made an educated guess as to which one signed it. The label was corrected as soon as the error was discovered. With regard to the shorted prescription, the Complainant insisted that he was given ninety-two (92) instead of ninety (90) tablets. The prescription was partially filled because they were short on the medicine, so the Complainant had two (2) bottles, one with forty (40) tablets and the other with fifty (50) tablets. The technician counted the pills and said that there were ten (10) extra tablets. The technician recounted the tablets and made sure that there were ninety (90) total and gave the bottles back to the Complainant. The Complainant then called back and said that they shorted him eight (8) pills. Since she couldn't reason with the Complainant, the pharmacist gave the Complainant an additional eight (8) pills and told him not to come back to the pharmacy.

Previous Complaints: Pharmacy: None

DPh (AL): None

DPh (CL): None

Recommendation: Letter of Instruction to DPh (AL) for placing the wrong prescriber's name on the prescription.

Dr. Robert Shutt motioned to **dismiss** the complaint; seconded by Dr. Sheila Mitchell. All were in favor and the motion carried.

6. Case No.: L03-PHR-RBS-200316800

A registered pharmacy technician was terminated from his employment after admitting to diverting five (5) Alprazolam 2mg tablets as well as other non-prescribed merchandise. The DEA 106 form submitted shows a total of eighty-five (85) Alprazolam missing.

November 18, 2003

Recommendation: Formal Hearing (Consent Order for Surrender/Revocation)

Dr. Robert Mitchell motioned to **accept the counsel's recommendation**; seconded by Dr. Reggie Dilliard. All were in favor and the motion carried.

7. Case No.: L03-PHR-RBS-200316505

The Complainant alleges that the pharmacist did not fill his prescriptions in a timely manner and the pharmacist is not obtaining refill authorizations from prescribing physicians when refills were requested. One specific incident is that the Complainant phoned-in a refill for ninety (90) Diazepam 5 mg to the pharmacy's automated answering service. The recorded message stated that the Complainant's prescription would be ready in one (1) to two (2) days. The Complainant went to the pharmacy in a day and a half and the pharmacist had still not called in the refill. The Complainant also alleges that on two (2) occasions, the pharmacy could not provide the entire amount of his prescription resulting in confusion about refills and refill dates. Also, the pharmacist alleged told the Complainant that the reason they do not provide the entire prescription is "in case someone else might need some." Lastly, the Complainant also alleges that the pharmacist has some bias against TennCare patients.

The pharmacist states that when the prescription for Diazepam was called into the pharmacy's automated voice system, the pharmacist was not working that day and was unaware of the problem until the Complainant came to the pharmacy. The pharmacist called in the refill while the Complainant was in the pharmacy.

*Previous Complaints: Pharmacy: 7/1999,(misfill, LOI)
DPh: None*

Recommendation: Dismissal

Dr. Robert Mitchell motioned to **dismiss** the complaint; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

8. Case No.: L03-PHR-RBS-200316463

The Complainant is a physician who treated a hospitalized patient for an overdose of Clonazepam. The physician was concerned that the pharmacy may have filled the prescriptions too early. The pharmacy investigator obtained a patient print-out, copies of the pharmacist notes and interviewed the PIC about the patient. The pharmacy files show that from October 6, 2002 to September 27, 2003, prescriptions for Clonazepam, Propoxy APAP 100, Tramadol 50 gm, Duragesic and Oxycodone were filled from thirteen (13) different physicians. When the investigator asked the PIC about refilling prescriptions for this patient too early, the PIC responded that he was aware that the patient had a drug problem. The PIC also stated that he made phone calls to the patient's doctors before each early refill was dispensed. However, there were no notes to document these actions or if the early refills were authorized by the physician. The PIC did have a patient profile with a medical history for a one (1) year period, a patient pain management contract, dismissal letter from the pain management doctor on August 30, 2003; the patient was advised to go to rehabilitation.

*Previous Complaints: Pharmacy: None
PIC: (1982 refilled CS without Rx, probation)
DPh: None*

November 18, 2003

Recommendation: Letter of Warning to the DPh and the PIC about proper documentation of contact with physicians and DURs.

Dr. Reggie Dillaird motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

9. Case No.: L03-PHR-RBS-200316440

The Complainant alleges that she only received four (4) instead of the requested five (5) refills of Hydrocodone. The PIC explained that the technician gave one (1) of the refills to another patient with the same last name. The pharmacy replaced the refill. The Complainant further alleges that the initials ZZZ were in the pharmacist initials slot on the label, but that no ZZZ works at the pharmacy. The letters ZZZ were placed on the label because it was an internet refill with a slash and a space for the initials of the pharmacist who is on duty.

Previous Complaints: Pharmacy: None

D.Ph.: 11/97, Counseling, CO \$100.00)

Recommendation: Letter of Instruction to Pharmacy suggesting that a policy and procedures review be completed and that the PIC conduct an in-service training for staff about proper procedures for dispensing to patients.

Dr. Robert Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

10. Case No.: L03-PHR-RBS-200316076

The Complainant alleges that his prescription for Meperidine 50 mg had no effect on his pain. When the Complainant ingested his second prescription of the drug (two (2) weeks later, same strength) which was filled by a different pharmacy, he noticed that it immediately affected his pain and the tablets from the two (2) prescriptions did not resemble each one another. The pharmacist proposed that the only explanation that can be given to account for the difference in the tablet's appearance is that the pharmacies used two (2) different manufacturers. The pharmacist stated that they also conducted an inventory of Meperidine and the count is exactly correct. None of the original product dispensed is available for comparison to determine if there was a misfill.

Previous Complaints: Pharmacy: None

PIC: None

DPh: None

Recommendation: Dismissal

Dr. Robert Shutt motioned to **accept counsel's recommendation**; seconded by Dr. Sheila Mitchell. All were in favor and the motion carried.

11. Case No.: L03-PHR-RBS-200315913

The complaint alleges that during the course of a routine compliance inspection, the investigator observed four (4) certified pharmacy technicians being supervised by one (1) pharmacist. One (1) of the technicians

November 18, 2003

was scheduled to be a cashier; however, she was observed reconstituting a liquid. The other technicians were observed inputting prescriptions, counting and filling orders.

*Previous Complaints: Pharmacy: None
PIC: None*

Recommendation: Consent Order with a \$100.00 civil penalty

Mrs. Barbara McAndrew motioned to **accept counsel's recommendation**; seconded by Dr. Reggie Dilliard. All were in favor and the motion carried.

12. Case No.: L03-PHR-RBS-200315915

The Complainant alleges that she was forced to make three (3) trips to the pharmacy unnecessarily to get her prescription for Tegretol 200 mg and then had to wait 30 to 45 minutes for it to be filled. The Complainant further claims that the uncertainty of this situation caused her emotional distress. The pharmacy offered to supply 100 mg tablets, but she refused. The PIC states that the Complainant's prescription was for ninety (90) tablets, but the pharmacy only had eight (8) tablets in stock and the patient was told to return the next day. However, the primary wholesaler was out of stock and the medication was reordered from a secondary supplier and it was delivered two (2) days later.

*Previous Complaint: Pharmacy: (4/01, misplaced C-II Rx, LOI)
PIC: (4/01, misplaced C-II Rx, LOI)
D.Ph.: (4/01, counseling violation, civil penalty \$100.00)*

Recommendation: Dismissal

Dr. Reggie Dilliard motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

13. Case No.: L03-PHR-RBS-200315843

The complaint alleges that during a routine compliance inspection of the pharmacy, the investigator noted that there were several prescriptions for Oxycodone filled for the pharmacist's brother. During the interview, the pharmacist told the investigator that her brother suffered from cluster headaches and that he had become addicted. According to the investigator, the pharmacist further stated that she was filling these prescriptions because no other pharmacist would fill them. There was no indication that the prescriptions were forged or that the pharmacist was dispensing the medication without a prescription; the only issue is that the pharmacist is filling controlled substance prescriptions for her brother. The pharmacist replied that the patient is in fact her brother and that although his current diagnosis is cluster headaches, his problem is primarily is Charcot-Marie-Tooth neuropathy, a genetic disease resulting in muscle atrophy and nerve degeneration. The pharmacist also stated that her statements made to the investigator that her brother was "addicted" were misconstrued, but the pharmacist did indicate that her brother may be physically dependent since he has been on opiate therapy for two (2) years. The pharmacist denied that she is filling these prescriptions because no other pharmacist would fill them. The prescriptions have been subjected to the DUR requirements and passed the Board investigator's scrutiny in 2001 and 2002. The pharmacist noted that her brother has tried other treatments in the past, but they have been unsuccessful; however, her brother has future appointments with specialists to explore alternative treatments.

November 18, 2003

Previous Complaints: Pharmacy: None

D.Ph.: None

Recommendation: Dismissal

Dr. Robert Shutt motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

14. Case No.: L03-PHR-RBS-200315790

The complaint alleges that during a routine compliance inspection, an investigator observed that the pharmacy was open for seventeen (17) minutes, but there was only a technician and no pharmacist was present. The pharmacist admits that she was not present at the pharmacy for approximately twenty-five (25) minutes in the middle of the day, but that she posted a sign stating "pharmacist not on duty". Although no prescription orders were received, filed or dispensed during the pharmacist's absence, the pharmacist did not fully comply with Rule 1140-3-.07 in that she did not close off the prescription department by a physical barrier.

Previous Complaints: Pharmacy: None

D.Ph.: None

Recommendation: Letter of Warning

Dr. Robert Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Sheila Mitchell. All were in favor and the motion carried.

15. Case No.: L03-PHR-RBS-200315656

The complaint alleges that during a routine compliance inspection an investigator noticed that there were a lot of out-of-date drugs on the shelves of the pharmacy. A check of the pharmacy's past inspection revealed that the four (4) previous inspections noted the same problem. The pharmacist was instructed by the investigator to remedy the problem and advise the Board of the actions taken. We received a response from the pharmacist within ten (10) days after the inspection stating that all of the out-of-date drugs had been destroyed or returned. The investigator made a return visit to the pharmacy approximately thirty (30) days thereafter and confirmed that there were no out-of-date drugs that remained on the shelves.

Previous Complaints: Pharmacy: 1/83, (unable to acc't for CS, 3 yrs. Probation, \$750.00 civil penalty)

D.Ph.: 1/83, (unable to acc't for CS, 3 yrs. Probation, \$750.00 civil penalty); 1/95, misfill, reg. letter).

Recommendation: Consent Order with a \$250.00 civil penalty.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Mitchell. All were in favor and the motion carried.

16. Case No.: L03-PHR-RBS-200315590

The Complainant alleges that her child's prescription for Methylphenidate ("MPH") was mistakenly filled with Methadone. The patient, who is a minor, consumed the medication and experienced nose bleeds,

November 18, 2003

drowsiness, lethargy and dizziness. The Complainant's mother called the pharmacy the next day to see if the prescription was filled incorrectly and the pharmacy assured her that it was the correct medication and that the pill had changed size. The Complainant kept giving the medication to her son for two (2) more days. The Complainant called the pharmacy again and the pharmacist told her to bring in the medication. When the pharmacist saw the medication, he identified it as Methadone. The pharmacist admits the misfill and states that he misfill was not identified the first time the Complainant called because the Complainant could not provide complete information about the tablet imprint.

The pharmacist states that they have increased their methods of checking the accuracy of all prescriptions now.

Previous Complaints: Pharmacy: None

D.Ph.(DW): None

D.Ph. (BB): None

Recommendation: Letter of Warning.

Dr. Sheila Mitchell motioned to **issue a Consent Order with a civil penalty of \$250**; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

17. Case No.: L03-PHR-RBS-200315585

The Complainant alleges that her prescription for Etodolac ER was shorted by ten (10) tablets. The Complainant came back to the pharmacy and she was given the remainder of the pills. The D.Ph. does not dispute the incident as recited by the Complainant.

Previous Complaints: Pharmacy: None

PIC: None

Recommendation: Dismissal on the merits; Consent Order with a \$50.00 civil penalty for failure to respond to complaint.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

18. Case No.: L03-PHR-RBS-200315105

The Complainant alleges that her prescription for Atenolol 50 mg was mistakenly filled with Furosemide 40 mg. The Complainant did not consume any medication. The D.Ph. admits the misfill and states that Atenolol and Furosemide are look-alike drugs that are located next to each other in the Baker cell system. The D.Ph. caught the error when he was reconciling the day's totals, but was unable to identify the patient who received the incorrect medication. The pharmacy has remedied the recurrence of this problem by separating the two (2) drugs in the Baker cell system.

Previous Complaints: Pharmacy: None

D.Ph.: None

Recommendation: Letter of Warning to D.Ph.

November 18, 2003

Dr. Robert Shutt motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

19. Case No.: L03-PHR-RBS-200312240

The Complainant alleges that his daughter's prescription for Grifulvin V 125 mg suspension for ringworm was misfilled because the prescription bottle had a label underneath the label for the Complainant's daughter that revealed that another gentlemen received the same medication that his daughter received, but with different dosage directions. An inspection of the Complainant's bottle revealed that he did receive the correct medication. Although the complaint was hand-delivered to the pharmacist, we did not receive a response.

Recommendation: Letter of Warning about protecting confidential patient information and a Consent Order with a \$50.00 civil penalty for failing to respond to the complaint.

Dr. Robert Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

20. Case No.: L02-PHR-RBS-200211755

The complaint alleges that during a routine compliance inspection, on December 16, 2002, an investigator observed the pharmacist working with an expired license; the pharmacist's license expired on August 31, 2002. The pharmacist admits the violation and states that she had been unable to obtain five (5) hours of live continuing education hours because she was unable to get off work to attend seminars.

Pharmacy:

D.Ph.: None

Recommendation: Consent Order with a civil penalty of \$400.00 to the D.Ph. for working with an expired license and a civil penalty of \$400.00 to the pharmacy. Letter of Warning to the pharmacy instructing them to advise the Board of the current policy in place to address this problem and any changes made to that policy as a result of this incident.

Dr. Robert Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Reggie Dilliard. An **amendment to the motion was made by Dr. Robert Mitchell to send a letter to the pharmacy supervisor**; seconded by Dr. Reggie Dilliard. All were in favor of the amendment to the motion; all were in favor the motion. The motion carried.

21. Case No.: L02-PHR-RBS-200210551

The Complainant alleges that his prescription for Monopril 10 mg was mistakenly filled with Pravachol 10 mg. The Complainant did not ingest any of the medication. The Complainant also alleges that the a similar error occurred in the past with his wife's medication. The D.Ph. admits the error and blames it on human error. The D.Ph. further states that he and the PIC have considered a number of methods to prevent a recurrence. With regard to the other error referenced in the complaint, the PIC states that there was not an error in dispensing this medication. The prescription was written in the Complainant's name and dispensed in his name, but he said it was for his wife.

Previous Complaints: Pharmacy: None

November 18, 2003

PIC: None

D.Ph.: None

Recommendation: Letter of Warning to D.Ph.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

22. Case No.: L02-PHR-RBS-200208217

The Complainant alleges that her prescription for Azmacort was mistakenly filled with Nasacort. The PIC states that it was as "called in" prescription and that it was filled as written. However, the PIC hypothesizes that the prescription may not have been correctly noted when it was called in.

Previous Complaints: Pharmacy:

PIC:

D.Ph.:

Recommendation: Dismissal

Dr. Robert Shutt motioned to **accept counsel's recommendation**; seconded by Dr. Robert Mitchell. All were in favor and the motion carried.

23. Case No.: L99-PHR-RBS-1999000222

The complaint alleges that someone was diverting Hydrocodone from three (3) pharmacy sites. The DEA 106 forms from the pharmacies indicate a loss of approximately 36,000 solid oral dosage units of Hydrocodone products. A recovering pharmacist who was terminated was suspected of diverting the Hydrocodone because he had worked at all three (3) pharmacies. The pharmacist denies taking the drugs, but admitted to taking three (3) Effexor and three (3) Trazadone for personal use because he left his prescriptions at home; he agreed to reimburse the company \$528.00 for those items. The pharmacist requested that he be allowed to submit to a urine screen twice, but that was denied and the pharmacist was terminated. The District Manager was contacted by our investigator and stated that the pharmacist was their primary suspect, but that they had no credible evidence. The Loss Prevention Supervisor was also contacted and he echoed the opinion of the District Manager, but that he had no other credible evidence as well. The Investigator then interviewed two (2) previous PICs who expressed concerns about the pharmacy's security and the use of numerous floater pharmacists. The pharmacist did seek out TPRN advocacy. TPRN informed us that all urine screens that they have conducted have been negative and that the pharmacist submitted to an evaluation which determined that the pharmacist had not relapsed.

Previous Complaints: Pharmacy:

PIC:

Recommendation: Letter of Warning for his admission to taking the Effexor and Trazadone. Letter to the pharmacy's Loss Prevention to perform an in-depth review of the security situation in the pharmacies and file a report with the Board.

Dr. Julie Frazier motioned to **accept counsel's recommendation plus request Loss Prevention to appear before the Board**; seconded by Dr. Reggie Dilliard. All were in favor and the motion carried.

24. Case No.: L01-PHR-RBS-200102221

The complaint alleges that in 2001, the pharmacist was pulled over by the police on a suspected DWI and found with a vial of Ativan and a syringe. The criminal charges were not pursued by the district attorney's office. An informal conference was conducted by Dr. Frazier, Dr. Lynch and myself with the pharmacist. The pharmacist admitted to taking the vial of Ativan and stated that at the time of the arrest, he was besieged with his own health problems and his wife's recently diagnosed Alzheimer's. The pharmacist also stated that he was previously treated for an alcohol problem and that he still consumes alcohol. At the informal conference, the pharmacist agreed to this resolution of the complaint and made contact with the TPRN with Dr. Lynch's assistance.

Recommendation: Consent Order to place the Respondent's license in inactive status and that the he must personally appear before the Board before his license is reactivated.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

25. Case No.: L02-PHR-RBS-200211754

This complaint was previously presented to the Board upon the allegation of substance abuse and the Board voted to suspend the pharmacist's license until he got a substance abuse evaluation. As a result of the evaluation, the pharmacist entered an impaired professional program where he received group therapy, individual therapy, etc. for 14-16 weeks. The pharmacist was recently discharged with an outpatient program plan with the following treatment recommendations: (a). Reestablishing in a good recovery program; (b). Attending weekly aftercare group meetings for six (6) months; and (c). Attending ninety (90) AA meetings in ninety (90) days. The diagnosis is Dysthymic Disorder; Opioid Dependency, partial remission; Amphetamine Dependency, long-term full remission and Alcohol Dependency, long-term full remission.

Recommendation: Consent Order taking the Respondent's license out of suspension and placing him on a five (5) year probation contract with the Board requiring TPRN advocacy or quarterly reports from the sponsor, urine screens, notifying us about his prescriptions and his primary care physician and to abstain from non-prescribed drugs and alcohol.

Dr. Sheila Mitchell motioned to **accept counsel's recommendation**; seconded by Dr. Julie Frazier. All were in favor and the motion carried.

**DISTRICT III MEETING – BILOXI, MISSISSIPPI
AUGUST 1 – 3, 2004**

Director Kendall Lynch stated the District III meeting will be held in Biloxi, Mississippi on August 1 – 3, 2004.

WAIVERS

CHHAYAL BHAKTA, DPH
1040 W. 27TH Avenue #409
Anchorage, AK 99503

Dr. Chhayal Bhakta is requesting a waiver of Rule 1140-5-.01 (1) relevant to the fifteen (15) Live ACPE hours for the renewal of her pharmacist license. Dr. Bhakta is currently residing in Alaska and is unable to obtain the Live continuing education hours. The Alaska Board of Pharmacy does not require the Live CE's.

Dr. Robert Shutt motioned to **grant the waiver request for this renewal period only**; seconded by Dr.

Sheila Mitchell. All were in favor and the motion carried.

MS. TERESA MORGAN
VICE PRESIDENT
PRECISION HEALTHCARE
1410 Donelson Pike #B-20
Nashville, TN 37217

Ms. Teresa Morgan is requesting a waiver of Rule 1140-3-.14 (12) relevant to pharmacist Pat Beckham being the pharmacist-in-charge at Precision Healthcare and The Baptist North Tower Hospital Pharmacy. The Baptist North Tower Hospital Pharmacy is a closed facility servicing the operating/recovery rooms and will work approximately twenty (20) hours/week. Dr. Sheila Mitchell motioned to **grant the PIC waiver through March 31, 2004**, while Precision Healthcare is pursuing a pharmacist in charge. Dr. Julie Frazier seconded the motion. All were in favor and the motion carried.

WILLIAM L. JONES, SR., DPH
3082 Maple Avenue
Milan, TN 38358

Dr. William L. Jones is requesting a waiver of Rule 1140-1-.07 (3) (c) (3) relevant to the NAPLEX examination for reinstatement of his pharmacist license. Dr. Jones' license had been in "inactive" status since May 14, 1997. Dr. Robert Mitchell motioned to **deny** the waiver request; seconded by Dr. Sheila Mitchell. All were in favor and the motion carried.

**NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
MPJE REVIEW**

The National Association of Boards of Pharmacy will conduct a review of the Multi-State Pharmacy Jurisprudence Examination at The Hilton in Scottsdale, Arizona on January 23 – 25, 2004. Pharmacist investigator Richard Hadden and either Dr. Robert Shutt or alternate, Dr. Sheila Mitchell will attend the meeting.

2004 UPDATE SEMINARS

February 7, 2004 (Saturday)	Cookeville, TN	Robert Mitchell
February 15, 2004 (Sunday)	Memphis, TN	Sheila Mitchell
February 29, 2004 (Sunday)	Knoxville, TN	Reggie Dilliard or Julie Frazier
March 6, 2004 (Saturday)	Kingsport, TN	Julie Frazier
March 13, 2004 (Saturday)	Chattanooga, TN	Forrest Parmley
April 4, 2004 (Sunday)	Nashville, TN	Reggie Dilliard or Julie Frazier
April 17, 2004 (Saturday)	Jackson, TN	Robert Shutt

Topics for discussion include the new proposed Rules, Tennessee Pharmacist Recovery Network, Controlled Substance DataBase; electronic prescriptions, HIPPA, inactive license status; nurse practitioner/physician assistant prescription writing; Pseudoephedrine; increased DEA fees and Buprenorphine.

**THURSTON MOORE, DPH – REQUEST FOR AN ACTIVE LICENSE
LAVERGNE, TN**

Dr. Thurston Moore appeared before the Board along with Dr. Tommy Malone to request a change in his license status to active. Director Kendall Lynch stated in 1983, Dr. Moore pled guilty to improper recordkeeping and was sentenced to three (3) years for the felony conviction. Dr. Moore was released in 1985.

In 1987, the Board refused to reinstate his pharmacist license due to a civil penalty not being C990paid. In 1991, Dr. Moore's license was reinstated with the TPRN contract with a probationary period of three years. In 1997, Dr. Moore relapsed and in September, 1997, received active status with the Tennessee Medical Foundation. In January, 2000, at the request of Dr. Moore, the license was surrendered due to exhibiting an incapacity of a nature that prevents a pharmacist from engaging in the practice of pharmacy with reasonable

November 18, 2003

skill, confidence and safety to the public. In November, 2001, the Board agreed to change Dr. Moore's license status from suspended to inactive/retired.

Dr. Julie Frazier recuse herself. After board discussion, Dr. Robert Mitchell motioned:

1. Respondent does hereby agree to the reinstatement of license number 4704 with the following probationary conditions. Said probation shall remain in effect for a period of five (5) years, from November 18, 2003 to November 18, 2008.

- (a) The Respondent shall completely abstain from the consumption of alcohol or any other drugs, except as specified in (b).
- (b) The Respondent shall be able to consume legend drugs or controlled substances prescribed by the Respondent's primary physician, William Maynard or Peter Martin, except in the case of an emergency or upon a proper referral from the Respondent's primary physician. The Respondent shall immediately notify the Board office in writing of the name of the Respondent's primary physician each time the Respondent changes primary physicians;
- (c) The Respondent shall not obtain or attempt to obtain any prescriptions in the Respondent's name for any legend drugs, controlled substances or devices containing same from a physician other than the Respondent's primary physician or from any other health care provider, such as a nurse practitioner, physician's assistant or psychiatrist;
- (d) The Respondent shall destroy any unused controlled substances prescribed under the provisions of subsection (b) no later than thirty (30) days following the completion of the prescribed course of treatment;
- (e) The Respondent shall report to the Board, in writing, the ingestion of any and all legend drugs or controlled substances (a copy of the prescription will satisfy the requirement);

- (f) The Respondent shall submit to random sampling of urine, blood or bodily tissues for the presence of drugs and alcohol, at the Respondent's own expense, by agents of the Board, such as the Concerned Pharmacists Group for as long as the Respondent has an active license. In the event that the sampling indicates the presence of drugs for which the Respondent does not have a valid prescription or the sampling indicates the presence of alcohol, then formal disciplinary charges may be brought against the Respondent which could result in the revocation of the Respondent's remaining term of probation or the suspension or revocation of the Respondent's license to engage in the practice of pharmacy. Prior to such disciplinary charges being heard by the Board, the Respondent's license may be summarily suspended;
- (g) The Respondent shall comply with all of the terms and conditions of the extended aftercare contract he or she entered into with Concerned Pharmacists Group. Respondent shall return a copy of said contract with this Consent Order to the Board office;
- (h) The Respondent shall not serve as pharmacist-in-charge of any pharmacy other than that approved by the Concerned Pharmacists Group "CPG" and/or the Board of Pharmacy for a period of three (3) years, however, after a period of two (2) years, the Respondent may petition the Board for a modification of this Consent Order to remove the restrictions upon a show of good cause. The Respondent shall not work as a "floater" for a period of three (3) years, meaning that the Respondent shall not work at more than one (1) pharmacy location at the same time without the permission of the Board;

November 18, 2003

- (i) If the license has been inactive, delinquent, suspended or revoked:(ii) **One (1) year to not more than five (5) consecutive years, the pharmacist shall:**

- I. Provide written notice requesting an active license;
- II. Satisfy all past due continuing pharmaceutical education;
- II. Successfully complete the jurisprudence examination;
- III. Pay all cumulative license renewal fees and any applicable penalties;
- IV. Complete a period of pharmacy internship in Tennessee.

- A. From one (1) year to not more than three (3) consecutive years, one hundred sixty (160) hours within one-hundred and eighty (180) consecutive days;

Dr. Sheila Mitchell seconded the motion. An amendment to the motion was made by Dr. Robert Mitchell. The pharmacy must be approved by the CPG and/or the Board of Pharmacy. The PIC at the location must be approved by the CPG and/or the Board of Pharmacy and a monthly inventory of controlled substances must be sent to the Board of Pharmacy. Dr. Sheila Mitchell seconded the motion. The Board adopted the motion as amended. All were in favor and the motion carried.

JOHN BEAUREGARD, PHARMACIST INVESTIGATOR JACKSON, TN

Director Kendall Lynch informed the Board that Dr. John Beauregard retired from state government on October 31, 2003. In honor of Dr. Beauregard's personal and professional contributions and achievements, the Board of Pharmacy appreciates his dedication. Dr. Sheila Mitchell motioned to **approve** the Resolution; seconded by Dr. Robert Shutt. All were in favor and the motion carried.

THERAPEUTIC INTERCHANGE OR FORMULARY SUBSTITUTION

Tennessee Board of Pharmacy

November 18, 2003

The Board discussed the demand being made on pharmacists as a result of the TennCare PDL. The Board reviewed a rule that was promulgated by the State of Kentucky discussing the issues and referred it to legal counsel for review.

**CALIFORNIA STATE BOARD OF PHARMACY
NAPLEX/MPJE**

Effective January 1, 2004, the California State Board of Pharmacy will participate in the NAPLEX and MPJE Examinations, which was signed into law on September 26, 2003. Dr. Kendall Lynch stated there has not been a decision made relevant to reciprocity due to California being an associate member of the National Association of Boards of Pharmacy.

ADJOURNMENT

Dr. Parmley announced there would be no Board of Pharmacy meeting on Wednesday, November 19, 2003. Dr. Julie Frazier motioned to adjourn the Board of Pharmacy meeting on Tuesday, November 18, 2003; at 3:30 p.m. CST; seconded by Mrs. Barbara McAndrew. All were in favor and the motion carried.

Respectfully submitted,

Forrest Parmley, President

Kendall M. Lynch, Director